



**INSTABILITY OF PUBLIC HEALTH INSURANCE COVERAGE
FOR CHILDREN AND THEIR FAMILIES:
CAUSES, CONSEQUENCES, AND REMEDIES**

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ABSTRACT: This report examines the extent, causes, and consequences of instability in public coverage programs for children and families. It focuses particularly on the phenomenon of “churning,” which occurs when individuals lose and regain coverage in a short period of time. It also looks at strategies to make public program coverage more stable for children and families. Findings are drawn from a variety of sources, including national and state-based studies, roundtable discussions and interviews with stakeholders and experts, and an examination of the effect of state and local policies on instability and churning in four states: Louisiana, Rhode Island, Virginia, and Washington. The experiences of these states demonstrate that coverage instability can be averted to a significant degree by adopting key policies and procedures, like limiting the frequency of required renewals; developing easy, seamless transitions among public coverage programs; and setting affordable limits on premium costs.

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EXECUTIVE SUMMARY

Instability in coverage is a natural outgrowth of the patchwork health insurance system in the United States. People covered through employer-based insurance may lose coverage if they change jobs, their employer decides to stop offering insurance, or their share of the cost of the coverage becomes unaffordable. Coverage gaps also arise when people try to move from employer-based to public coverage, because the process is rarely facilitated and a large portion of those who lose job-based coverage are not eligible for public coverage. In addition, gaps occur within public coverage programs, triggered either by changes in family circumstances that make individuals ineligible for public insurance or by administrative complexity or other difficulties that result in failure to renew coverage. One study showed that over a four-year period, nearly four of 10 Americans under the age of 65 experienced one or more gaps in private or public health insurance coverage.

This report examines the extent, causes, and consequences of instability in public coverage programs for children and families. It focuses particularly on the phenomenon of “churning,” which occurs when individuals lose and regain coverage in a short period of time, suggesting that the loss of coverage is not due to eligibility factors. It also looks at strategies that can make public program coverage more stable for children and families.

The findings are drawn from a variety of sources, including national and state studies, roundtable discussions and interviews with stakeholders and experts, and an in-depth examination of how state and local policies have affected instability and churning in four states: Louisiana, Rhode Island, Virginia, and Washington. The states were chosen based on their demonstrated interest in the issue of churning, the potential to find useful data, and a willingness on the part of state officials to participate. For a full discussion of the study states, see the Appendix.

Paying attention to the problem of coverage instability within public insurance programs, chiefly Medicaid and the State Children’s Health Insurance Program (SCHIP), makes sense for several reasons.

- Coverage instability affects millions of children and families each year, taking a considerable toll on their ability to access needed health care in a timely manner and in an appropriate and cost-effective setting.
- Instability and churning result in a substantial amount of wasted time and spending. Medicaid and SCHIP officials, as well as health plans and providers that serve Medicaid and SCHIP enrollees, report significant costs related to churning.

- Solutions are at hand; coverage instability and churning on and off of public coverage are not intractable problems.

Churning Has Significant Consequences

Interventions to avert unnecessary instability and churning are important because the consequences in terms of health care delivery and costs are significant. While there is no single source of data on the extent of instability and churning in Medicaid and SCHIP, program administrators, health plan executives, and health providers agree that the problem is substantial. For example:

- Data from Louisiana show that over a two-year period, beginning in January 1999, 18 percent of children had a gap in Medicaid coverage. After significant changes in policy and practices, that proportion declined to 6 percent over a two-year period, beginning in January 2003.
- Data from Rhode Island's Medicaid agency show that one of four enrollees had a gap in Medicaid coverage over a 12-month period. Churning was common; about 60 percent returned to the program within the year.
- Virginia found that over an 18-month period, beginning in March 2004, about one-third of the children enrolled in Medicaid or SCHIP lost their coverage at some point.
- Washington's Medicaid agency found that in a three-month period in 2004, more than one-third (36%) of children whose coverage was terminated were reenrolled.

The consequences of instability and churning are wide-ranging and affect states and localities, health plans, and health care providers as well as consumers (Table 1).

Table ES-1. Consequences of Insurance Instability and Churning

Consequences	Groups Most Affected			
	States and Localities	Health Plans	Providers	Consumers
Costs associated with enrolling, disenrolling, and reenrolling beneficiaries, including extra paperwork, system updates, extra mailings	✓	✓	✓	
Costs associated with delivering “new member” services multiple times		✓	✓	
Additional administrative costs associated with researching and reconciling billing problems	✓	✓	✓	
Costs associated with verifying enrollment status, counseling consumers about coverage status, and assisting with enrollment	✓	✓	✓	
Extra investments to attempt to help families retain coverage	✓	✓	✓	
Extra staff time and costs to track and assist individuals participating in disease management programs who have lost coverage		✓	✓	
Reduced effectiveness of disease management programs	✓	✓	✓	✓
Cost-shifting and depleted resources when Medicaid or SCHIP payments are not available to reimburse safety-net providers	✓		✓	✓
Compromised continuity of care as returning enrollees are assigned to different plans or providers		✓	✓	✓
More difficulty measuring quality of care	✓	✓	✓	✓
Difficulty arranging care, particularly specialty care			✓	✓
Difficulty getting care, including preventive care				✓
Unmet health care needs				✓
Care provided in inappropriate settings	✓	✓	✓	✓
Higher costs for care when individuals reenroll	✓	✓	✓	✓

Source: Authors’ analysis of data.

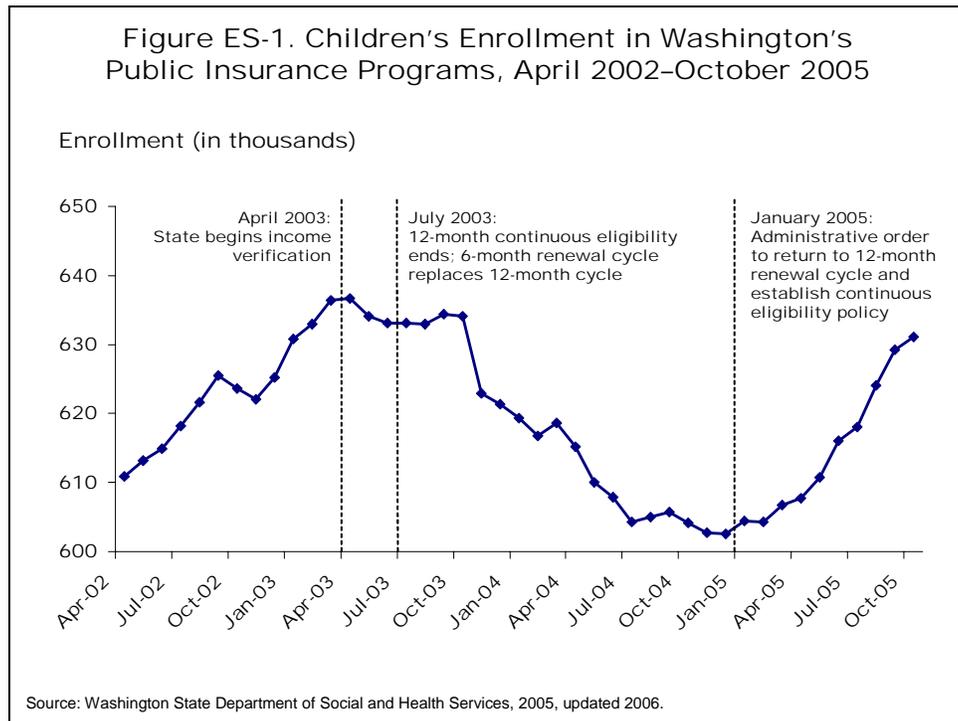
Changes in Public Programs Can Substantially Reduce Churning

The causes of churning have been examined over the past several years and a range of practices that can contribute to coverage stability has been identified. However, a close

examination of state experiences shows that these steps, taken in isolation, may have only limited value unless states commit to systemic changes.

Preventing loss of coverage at renewals. Churning is driven to a significant degree by low public coverage renewal rates. Many states have attempted to reduce renewal problems by developing simplified forms, streamlining verification requirements, and providing renewal assistance. These are important steps, but solutions that appear to have the greatest impact go to the heart of the problem: reducing the frequency of renewals and eliminating renewal requests when needed information is already on hand.

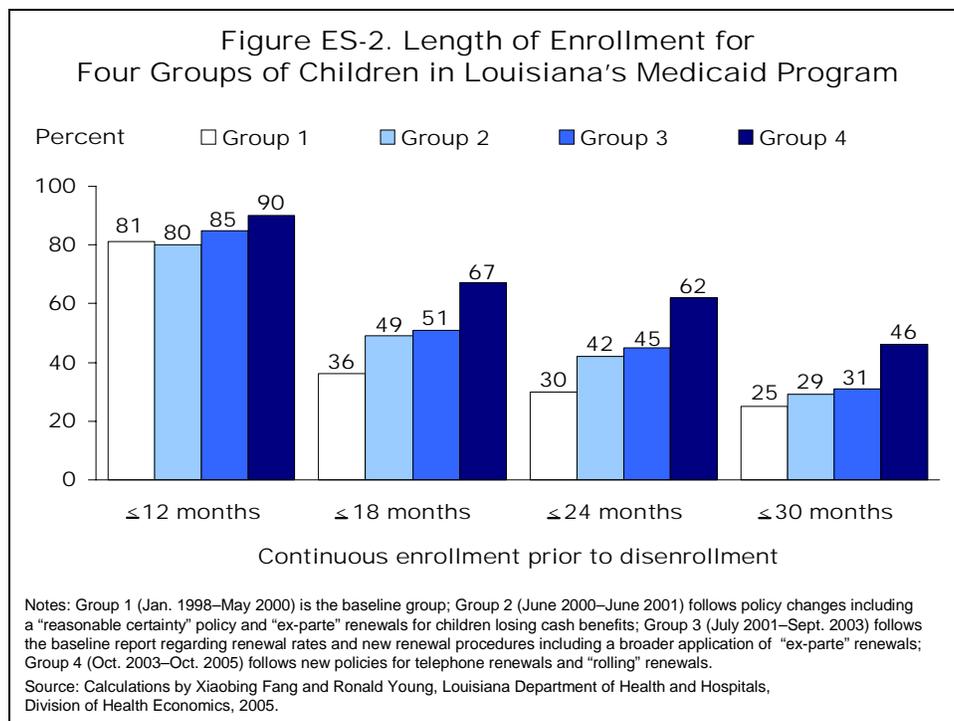
Washington’s experience highlights the extent to which frequent renewals contribute to coverage gaps and instability. In 2003, as a result of budget pressures, Washington reversed some of the steps it had taken in earlier years. It eliminated “continuous” eligibility and required families to renew their eligibility every six months instead of annually. When the state reversed course yet again and returned to 12-month renewal periods, enrollment rebounded (Figure ES-1).



Louisiana has eliminated traditional renewals when it already has the information needed to evaluate children’s ongoing eligibility through other program records and state databases. Instead of automatically sending renewal forms to families, the state conducts an internal eligibility review—or “ex parte” review—by examining Food Stamp Program

records and other information available to the Medicaid agency. Families can be contacted by telephone if additional information is needed to complete the review. With these procedures in place, the more formal and complicated renewal process proves unnecessary for two of three children, thus dramatically reducing the number of children who lose coverage at renewal. At the same time, administrative costs associated with the renewal process and churning have decreased.

In Louisiana, comprehensive changes in the renewal process were accompanied by an explicit philosophical decision to make retention among eligible children a priority. As a result, Louisiana significantly improved the continuity of coverage for children (Figure ES-2).



Preventing transitions across public programs from disrupting coverage. Even though eligibility for Medicaid is no longer linked in any way to eligibility for or receipt of food stamps or Temporary Assistance for Needy Families (TANF) benefits, system failures, administrative burdens, and the lack of clear information for families can result in the loss of Medicaid coverage when welfare or food stamp benefits stop. In states that cover children through two different child health coverage programs, shifts in eligibility between SCHIP and Medicaid also can result in coverage gaps.

Washington has taken a number of steps to correct problems that had led to the loss of health coverage. Twelve-month continuous eligibility and computer system changes ensure that when cash benefits for a child end, the child's eligibility status is changed in the database and medical benefits continue. The system also facilitates simple and relatively seamless transfers among the three public coverage programs for children.

Mitigating the impact of premiums on churning. Premiums in SCHIP and Medicaid may contribute to coverage instability and churning, under certain circumstances, and recent federal law changes might prompt more states to consider imposing premiums. States have authority to impose premiums in SCHIP, subject to certain limitations, and now the Deficit Reduction Act of 2005 allows states to charge premiums in Medicaid for children whose family income is above 150 percent of the federal poverty line. The extent of coverage loss and churning that might result from premiums will depend on several factors, including the amount of the premiums, income levels of the families required to pay the charges, number of family members covered by the premiums, and procedures in place to facilitate premium collections. Two of the study states—Rhode Island and Virginia—have had some experience with premiums and each has closely watched the impact that premium payments may be having on enrollment and disenrollment. Although a premium was charged initially for SCHIP coverage in Virginia, the premiums were discontinued in 2002 when data showed that large numbers of children would have lost coverage if sanctions for nonpayment were imposed as originally planned. Rhode Island is implementing new policies related to methods for paying premiums to lessen the coverage losses that have occurred among the relatively small portion of enrollees who are charged premiums in its Medicaid program.

Other Factors Help to Reduce Churning

Beyond a state's particular policies and procedures, two additional factors appear to reduce instability and churning: measuring enrollment dynamics and having strong leadership focused on securing coverage for eligible children and families.

Importance of routine, standardized measurement. Consistent, routine measurement can demonstrate what does and does not work and pinpoint any needed adjustments. It also can help to establish accountability among public program staff.

While all states collect enrollment data, not all collect the data needed to provide a clear picture of enrollment dynamics. At a minimum, it is important to know how many people are entering and exiting the program each month. Measuring renewal rates and understanding the reasons for loss of coverage at renewal will clarify how much churning

is occurring before and after interventions. In addition, longitudinal analyses that show enrollment patterns over time are essential to fully understand churning.

Many program and health plan administrators expressed a need for guidance about methods to measure insurance instability and churning. States vary considerably in terms of their capacity to report on renewal outcomes. Among states that track renewal outcomes or report on reasons for case closures, data elements and definitions differ considerably and coding regarding the reasons for loss of coverage is not precise. State-specific data on churning rates are limited and are not comparable across states because the analyses define and measure churning differently. Analysts noted that they would prefer not to “reinvent the wheel” and would welcome recommendations based on experience in other states. To set goals, administrators said that it would be helpful to know how to define and calculate a reasonable level of churning.

Leadership is key. The states’ experiences underscore the importance of providing strong leadership at the top and letting people on the ground improvise and adapt. States operating under gubernatorial directives to increase enrollment and stability of coverage are better positioned to conduct comprehensive reviews of program renewal procedures, make changes, and revisit policies when changes do not produce desired results. Each of the four states studied has shown considerable leadership and commitment to solving instability and churning problems.

Conclusion

Publicly funded coverage is the only source of coverage available to millions of low-income children, families, and working parents who have no access to affordable job-based insurance. Its potential effectiveness is compromised when coverage is unstable. Moreover, coverage instability and churning result in significant and unnecessary costs for states, health plans, providers, and families. The experiences of these four states demonstrate that coverage instability within public programs is not inevitable. It can be averted to a significant degree by adopting key policies and procedures. An ongoing commitment to ensuring coverage stability can produce measurable, sometimes strikingly positive results for children and families and the health care system more broadly.

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INTRODUCTION

America's patchwork health insurance system not only leaves millions of people without coverage but also causes gaps in coverage and frequent changes in sources of coverage. Over the four-year period from 1996 through 1999, some 85 million nonelderly people experienced a gap in coverage—twice the number of uninsured at any point in time.¹

Individuals lose and regain insurance coverage for a variety of reasons. In our predominantly employer-based system, changes in health insurance status are most often driven by job-related changes, such as a new job, more or fewer hours of employment, or changes in employment status. In addition, the cost of job-based coverage affects employer offer rates, as well as employee participation.

In the absence of a broad overhaul of the health care system, a certain amount of movement in and out of coverage is inevitable. One cause of instability, however, is relatively easy to address. Policies or practices that make it difficult or burdensome for people to retain coverage through the publicly financed Medicaid or State Children's Health Insurance Program (SCHIP) can leave eligible people uninsured. Some individuals return to public health programs after a relatively short gap in coverage (a phenomenon referred to as "churning"). Others remain uninsured for longer periods of time. While estimates vary, it is clear that substantial inroads can be made in expanding coverage—particularly among children—by reducing the level of inappropriate (i.e., not related to eligibility) short and longer-term losses of public coverage.

Bolstering enrollment among eligible children will lead to coverage-related costs. Some states may be reluctant to bear such costs, particularly during times of tight budgets. But coverage instability and churning also result in costs, which are borne by families and, in less apparent ways, by states, health plans, and providers.

This report reviews the causes and consequences of public insurance instability, focusing particularly on children and family-based coverage. It offers recommendations grounded in the practical experiences of states over the past 10 years. It is based on findings from a variety of sources, including a literature review, state reports, roundtable discussions, and interviews with state officials, consumer representatives and advocates, health plan representatives, and safety net provider groups. In particular, researchers

focused on four states—Louisiana, Rhode Island, Virginia, and Washington—each of which offers a unique vantage point for observing the causes, consequences, and remedies for instability and churning (Table 1). Their experience demonstrates how certain policies, as well as political and economic circumstances, have a significant impact on total enrollment and the stability of enrollment among eligible children and families.

Table 1. The Four Study States

States	Program	Groups Covered (Percent of Federal Poverty Level)	Policies and Practices of Interest
Louisiana	Medicaid (LaCHIP)	Children <200% Parents <13%	<ul style="list-style-type: none"> • consistent and comprehensive efforts to avoid enrollment drops due to renewals • progress measured against baseline data • local retention efforts
Rhode Island	Medicaid (RIte Care)	Children <250% Parents <185%	<ul style="list-style-type: none"> • early recognition of the churning problem • expanded coverage to parents as well as children • resources devoted to data/research • stakeholders actively engaged with state to address problems • experience with premiums
Virginia	Medicaid (FAMIS Plus) SCHIP (FAMIS)	Children <200% Parents <24%	<ul style="list-style-type: none"> • strong gubernatorial leadership on increasing children’s enrollment • children covered through two separate programs • local retention efforts • experience with premiums
Washington	Medicaid (Family and Children’s Medical Programs) SCHIP	Children <250% Parents <43%	<ul style="list-style-type: none"> • experience with various changes affecting participation • resources devoted to data/research • children covered through two separate programs

Notes: Louisiana and Rhode Island use their SCHIP funds to expand Medicaid. Virginia operates a separate SCHIP program and SCHIP Medicaid Expansion program along with Medicaid. Washington operates a separate SCHIP program along with Medicaid. In 2006, 100 percent of the poverty level for a family of three is equivalent to \$1,383 in gross earnings a month.

EVIDENCE OF INSTABILITY

The substantial size of the uninsured population in the United States has received considerable attention. The Census Bureau reports that 45.8 million people—or 15.7 percent of the population—lacked health insurance in 2004.² Estimates of the number of people who lack insurance at a particular point in time, however, represent only a fraction of the number of people who lose and gain insurance, or “churn” through the insurance system over time.³ Despite the methodological differences among federal surveys and differing estimates derived from them, a relatively consistent picture of health coverage emerges.⁴ Substantially higher numbers of people have a spell without insurance over a period of time compared with the numbers of uninsured at one particular point in time.

Insurance Instability Is More Common Among Some Groups than Others

The low-income population is particularly susceptible to unstable coverage.⁵ There appears, also, to be an association between education and insurance stability, with more educated individuals more likely to have stable coverage than less-educated individuals.⁶

Race and ethnicity are strongly related to unstable coverage, with Hispanics at greater risk of discontinuous coverage and longer lapses in coverage than non-Hispanic whites or blacks.⁷ There also are significant differences between citizens and non-citizens, with the latter far more likely to experience gaps in coverage. Over a 12-month period, more than half of non-citizens were uninsured at some point, compared with about one-fifth of citizens.⁸

Compared with other age groups, children are less susceptible to coverage instability. Yet 42 percent of children under age 19 were uninsured at some point over a four-year period.⁹ Similar patterns have been reported over a two-year period, with more than one-third (34%) of individuals ages 17 to 22 and nearly one-quarter (23%) of children under age 17 experiencing one or more periods without insurance.¹⁰

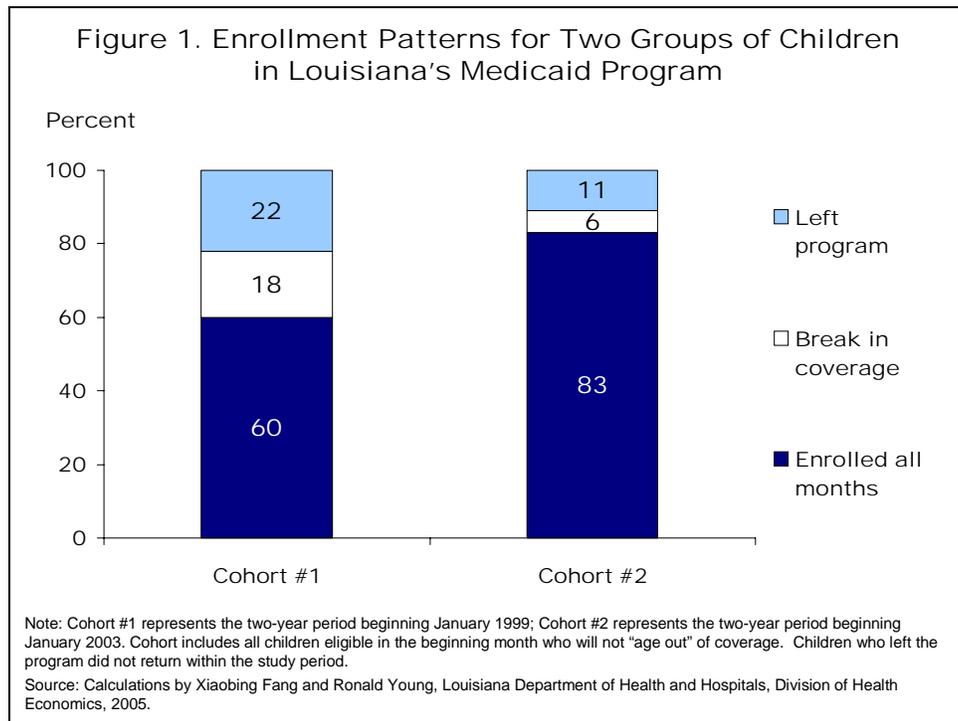
Individuals move in and out of both private and public coverage and may experience gaps in coverage when this occurs. Individuals whose jobs are not steady are at particularly high risk for unstable coverage. Gaps are common among the working poor and near-poor. Although there appears to be relatively little change in the overall distribution of public and private coverage from year to year, there is a great deal of movement between types of coverage.¹¹

Insurance Instability in Public Programs

Some of the instability within public coverage programs is due to people losing eligibility for public coverage and some is due to people moving to private coverage. However, instability is also due to people losing coverage because of procedural, rather than eligibility-related, reasons.

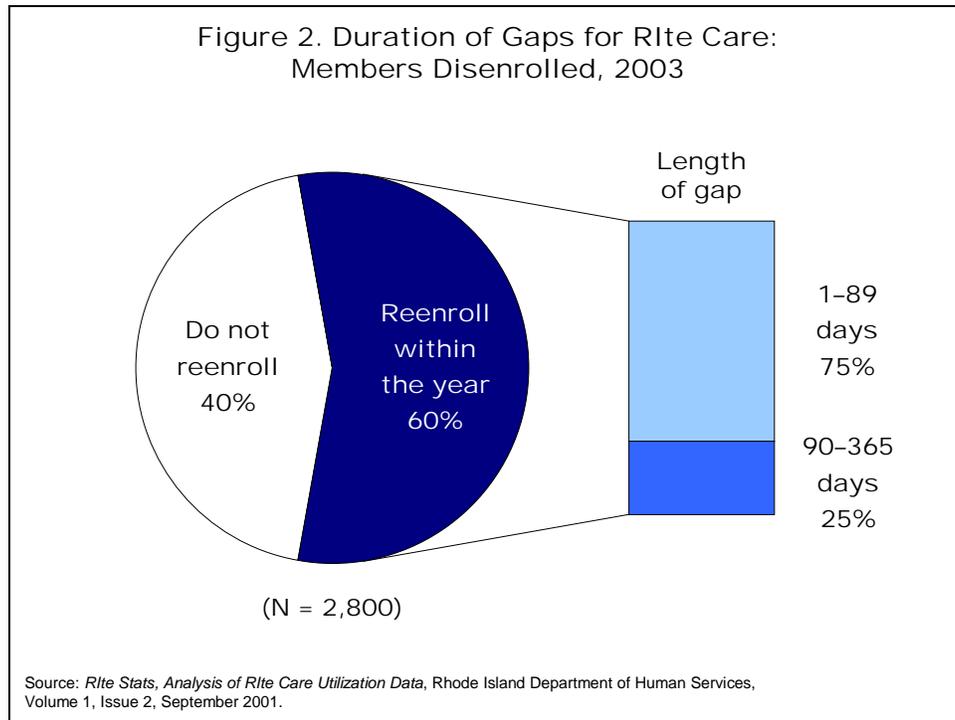
Data from the four study states show evidence of insurance instability in public coverage. The data generally do not show whether those with gaps in public coverage had private coverage during the gap, but other studies indicate that a substantial portion of low-income children who lose public coverage are uninsured.

Louisiana. Researchers from the Louisiana Department of Health and Hospital's Division of Health Economics examined public coverage enrollment patterns over a two-year period for cohorts of children enrolled in the program. As discussed below, after Louisiana simplified its renewal procedures, stability increased markedly. The proportion of children with breaks in public coverage decreased by two-thirds and the proportion leaving coverage decreased by half (Figure 1).

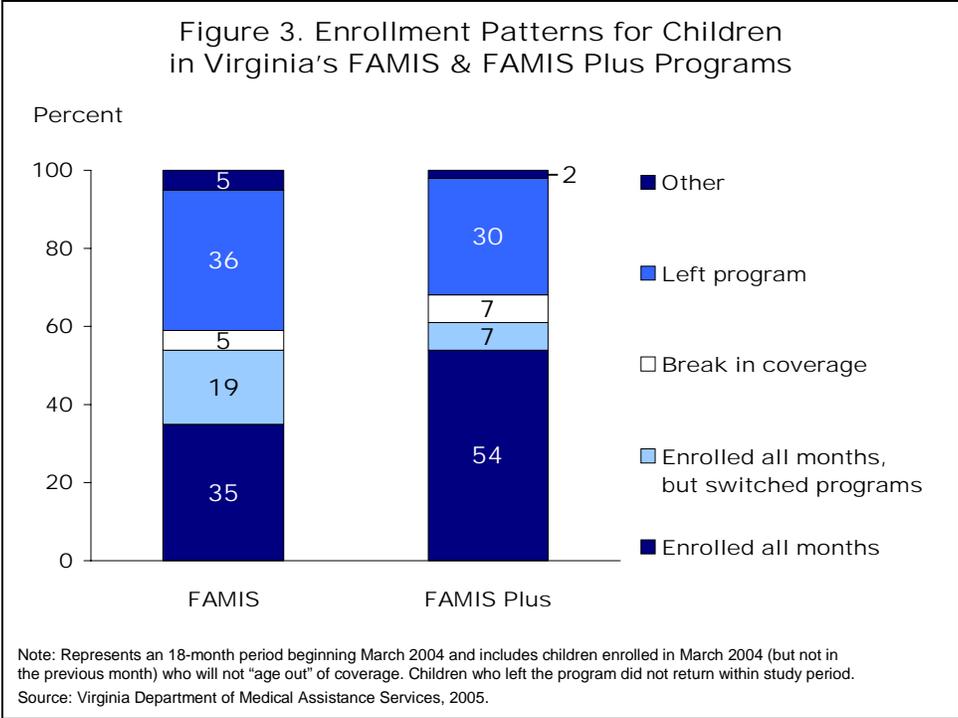


Rhode Island. Research from the Rhode Island Department of Human Services shows that about one-quarter of enrollees had a gap in RItE Care coverage during calendar year 2000.¹² Of the 2,800 individuals leaving the program in an average month,

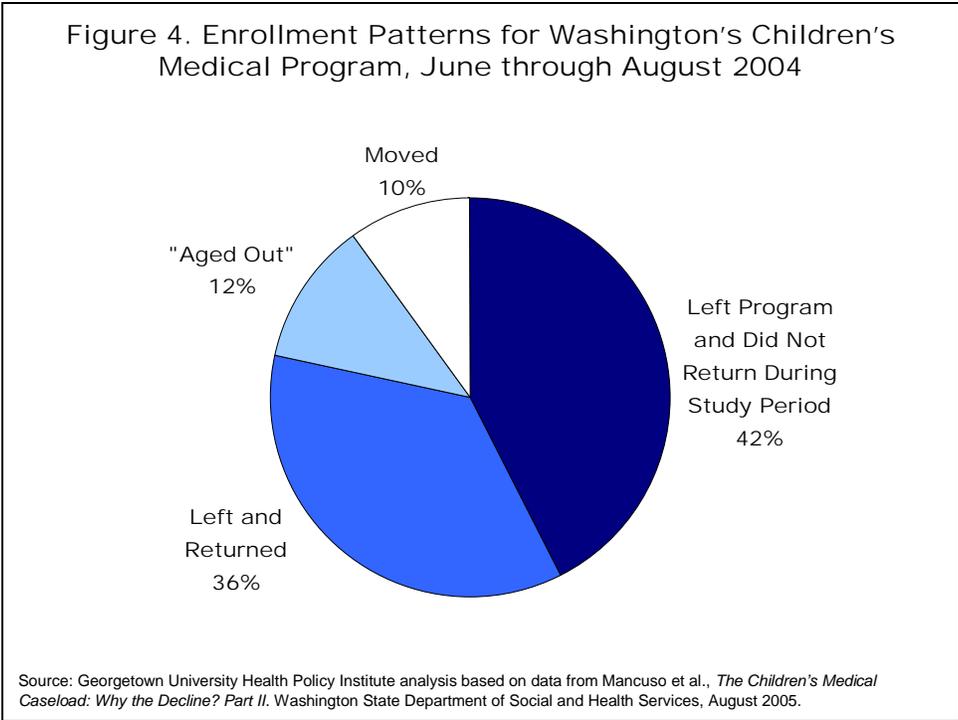
about 60 percent returned within the year. Among those returning, three-quarters returned within three months (Figure 2).



Virginia. An analysis of enrollment patterns in Virginia’s FAMIS and FAMIS Plus programs (SCHIP and Medicaid programs, respectively) also shows evidence of instability. Over a period of 18 months, beginning in March 2004, about one-third of the children left each program and a small portion left and returned within this relatively short period of time (Figure 3).



Washington. Evidence of churning in Washington comes from a study that examined enrollment patterns for the Children's Medical Program over a three-month period, from June through August 2004. In just that short period of time, among the children who left the program, more than one-third—almost 13,000 children—subsequently returned (Figure 4).



How Is Churning Measured?

Data from national surveys can be used to track coverage patterns for individuals and generally show the proportion of the population that loses and regains coverage over particular periods of time. The duration and frequency of gaps can be measured, and transitions among types of insurance can be identified. In addition, the data can be used to describe the characteristics of individuals by stability of coverage.

Attempts to measure churning in state public programs generally rely on program rather than population-based data. Some states have conducted longitudinal studies to track enrollment patterns for individuals. However, the program's information systems, which often are the source of data for the studies, are not designed specifically to identify and measure churning in public programs, and there are some data limitations. Factors that affect how churning is defined and measured include:

- *Retroactive coverage:* Under federal Medicaid rules, an applicant may be eligible for up to three months of retroactive coverage. For example, if a child loses eligibility and then reapplies two months later, he or she may be able to receive retroactive coverage for the intervening two months. This can provide significant help for families and providers, but retroactive coverage is not the same as “real-time” coverage. Optimally, therefore, studies on churning would seek to exclude or at least separately identify periods of retroactive coverage. State program information systems are generally designed to indicate the entire period for which reimbursement is available, including periods of retroactive eligibility. Therefore, data from these systems likely understate the extent to which churning occurs.
 - *Transitions:* In more than half of states, some children are covered through Medicaid while others are covered under separate programs funded through SCHIP. Transitions between the two programs are common, and should be treated as gaps only if the result is a period without insurance. Yet, state data systems cannot always differentiate between coverage terminations and transitions between programs. As a result, churning may be overstated.
 - *Length of coverage gap:* There is no standard definition of the length of a “churning-related” coverage gap.
-

Program management reports can provide limited, but still useful, information about the stability of coverage. For example:

- States that track *turnover* or the *ins and outs* of enrollment know how many people leave and enroll in the program each month.
- *Renewal rates* measure the proportion of program enrollees that successfully complete the renewal process. This is an important measure, given that failure to complete the renewal process is a factor associated with churning in public programs.
- Data on *reasons for failure to renew coverage* can provide more specific information about whether coverage ends because of problems with the renewal process, individuals are no longer eligible for coverage, or they obtained other coverage. Most states collect this type of information but it is not always complete or precise. Some states have conducted special surveys of individuals who have left public programs.

This report relies on data provided by states and research conducted using state data. When appropriate, the state definition and data limitations are identified. While the data can be used to examine the relationship between enrollment patterns and practices within a state, comparisons across states are generally not appropriate because of differences in definitions and reporting capacity.

CONSEQUENCES OF CHURNING IN PUBLIC PROGRAMS

Churning in public programs has significant and troubling consequences. Administrative costs are higher for states and localities, health plans, and health care providers as a result of churning. Health plans and providers lose anticipated revenue. Managing and monitoring care and measuring the quality of care are more difficult. Instability also affects access to care and may affect the cost of providing care. Researchers in Washington noted that churning had consequences that need to be “balanced against the savings accruing from falling caseloads. These include well-being impacts on children who have gaps in medical coverage, disruption of enrollment in Healthy Options managed care plans, and workload impacts on Community Services Office staff from more frequent eligibility reviews.”¹³

Higher Administrative Costs for States and Localities

The precise level of the administrative costs related to churning is difficult to quantify, but state officials consistently report that when large numbers of people disenroll from public

health insurance programs and subsequently reenroll, the cost of running their public coverage programs is higher than it would be with more stable enrollment.¹⁴

More frequent renewals, which contribute to churning, are also costly. After Washington implemented policies in 2003 requiring that renewals occur every six months, rather than annually, and adding new verification steps, the cost of administering the Children’s Medical Program increased. Early estimates showed that administrative costs would grow by \$3.5 million annually as a result of the shorter certification period and by \$2 million for income verification requirements. The state legislature appropriated funds to hire new staff to process the anticipated increased volume of renewals, but backlogs of initial applications and renewals still occur.¹⁵ Additional temporary staff members were hired to contend with the backlog.

Connecticut had a similar experience when it eliminated a previously adopted simplification—12-month continuous eligibility—in an effort to realize program savings. The state Medicaid director has noted that the policy change may have been “shortsighted” because of the increased administrative workload and costs associated with having to conduct re-determinations more frequently.¹⁶

Increased Financial Burdens for Health Plans

There is a general consensus among health plan administrators that costs to plans related to churning are substantial. These costs arise as a result of extra paperwork, system updates required when members lose and regain coverage, and the expense of mailings sent to members to advise them that their coverage has been terminated or to welcome returning members to the plan. In addition, plans report that they spend considerable time resolving billing issues, reconciling claims and the coverage status of plan members who lose and regain coverage, and counseling current and former members about their coverage status.¹⁷

One large managed care organization in Virginia with approximately 75,000 FAMIS and FAMIS Plus members estimated, based on costs in 2003 and 2004, that the extra expense associated with disenrollment and reinstatement tasks related to churning was \$286,000 on an annual basis. The Neighborhood Health Plan of Rhode Island, which has about 75,000 members enrolled through RItE Care, reports that disenrollment and reinstatement tasks associated with churning cost the plan about \$230,000 annually.

Another health plan in Virginia, Optima, reports that about 3,300 FAMIS or FAMIS Plus members are added each month. Of those, 43 percent are returning after a gap of less than a year. (These are plan gaps, but generally they occur because of coverage

gaps.) Those who have had a break in plan coverage lasting six to 12 months receive a home visit, while those with a shorter break receive a welcome-back call. In either case, the process is time- and resource-intensive. As one plan administrator notes, “Clearly, a shift in reenrollment numbers would mean that we could focus our staff on other quality improvement efforts.”¹⁸ Plan administrators say that even relatively small costs, such as the \$12 to \$15 for a new membership card and welcome packet, mount up when churning occurs.

Plans invest in retaining members. Another indication of the cost of churning to plans is that many have made a business decision to be proactive in promoting stability of coverage for their members to avoid or lessen the costs associated with churning.

The Neighborhood Health Plan of Rhode Island estimates that annual spending for reminder calls to members who are due to renew coverage is \$187,000. The plan also has developed a system to check addresses and send changes to the state so that renewal forms will be sent to members’ correct addresses. This costs about \$33,000 annually. In addition, half of the plan’s expenditures for outreach activities are devoted to educating prospective and current members about the renewal process. Member services staff at Virginia’s Optima Health Plans also send notices of address changes to Virginia’s Department of Medical Assistance Services on behalf of members.

Three relatively large health plans in New York report that they spend almost \$70 per member in staff costs to assist members with recertification for Child Health Plus B, New York’s SCHIP program.

Churning may increase financial risk for plans. Plans report that their efforts to reduce churning are a response, in part, to the concern that they may be at financial risk for the loss of anticipated revenue during periods of disenrollment. Although plans do not receive capitated payments for the months when members are not enrolled, they may still incur costs related to managing care. For example, plans may help members with chronic conditions to obtain the medicines or services they need from other sources.¹⁹ The Community Health Center Network of Washington, a health plan, reports that health centers continue to see patients even if they lose their insurance. As a result, the plan incurred millions of dollars in uncompensated care costs after policy changes led to an increase in the number of children without insurance.²⁰

Plans’ efforts to reduce churning among all members may also reflect attempts to balance the mix of members. There is some evidence that less churning may occur among

sicker enrollees. Health status appears to have some relation to the likelihood that children will remain enrolled in public programs, with sicker children more likely to remain.²¹ Thus, some plans have concluded that it is in their interests to limit churning to help ensure a balanced membership.

Administrative Costs for Providers

Costs increase for health care providers, like health clinics and hospitals, when patients have unstable health insurance coverage. These costs result primarily from staff having to spend time trying to reconcile billing and enrollment records if claims are denied and billing disputes arise. For example, several types of providers in Washington saw an increase in staff time and resources devoted to verifying enrollment status and solving enrollment problems following a policy change that required more frequent eligibility reviews.

Safety net providers face additional burdens. People with Medicaid or SCHIP coverage who receive much of their medical care through community health centers or health center managed care plans may continue to visit the centers, regardless of their insurance status. In fact, health center administrators report that many families are unaware of their insurance status until they arrive for care. Care, however, is nonetheless compromised and health centers themselves often bear new burdens.

Safety net providers are at financial risk if families continue to seek care after losing coverage, since Medicaid payments will be discontinued. The CEO at Eastern Shore Rural Health Services in Virginia notes that patients are seen at the community health center regardless of their insurance status. The center loses money if they see a person whose Medicaid coverage has lapsed because, instead of receiving the Medicaid reimbursement rate for the services, they charge the patient on a sliding-scale basis, which results in a lower payment.²² Administrators from the Thundermist Community Health Center in Rhode Island also report that families continue to come to the center, even if their coverage has lapsed and the center no longer receives capitated payments for their care. When premium requirements were introduced for some RIte Care enrollees, the center determined that it was to their financial advantage to establish a fund to pay premiums in some cases to ensure that coverage for the families would not lapse and the center would continue to receive capitation payments.²³

An administrator at Yakima Neighborhood Health Services in Washington reports that approximately one-third of the clinic's revenues were lost when the state switched to

a six-month enrollment period. Many children lost and later regained coverage but continued to come for care, regardless of their health insurance status.

Hospital staff in Washington report delays in Medicaid reimbursements and increased charity care due, in part, to frequent Medicaid status changes. The Washington State Hospital Association reports that hospital charity care increased dramatically during the period following the state's Medicaid renewal policy changes requiring more frequent renewals, ending the policy of continuous eligibility, and imposing new verification requirements—from \$68 million in 2000 to \$180 million in 2004. This extra charity care costs were due, in part, to the changes in the renewal process.²⁴

Health center staff also note that access to needed services is much more difficult to arrange when coverage lapses. Staff from the Thundermist Community Health Center report that, when children whose coverage has lapsed come to the center and receive primary care, “it’s not just business as usual. Primary care providers spend a significant amount of time trying to help patients get access to specialty care, laboratory services, and prescription drugs and they are not always successful.” Physicians from health centers in Rhode Island express particular frustration about the mandatory waiting period for reenrollment that follows nonpayment of premiums. They note instances when a child needed medication, surgery, or other services that could not be provided in a timely manner because the child did not have coverage due to sanctions for nonpayment of premiums.²⁵ In Washington, hospital staff reported longer waits for emergency room care and difficulties arranging specialty care, especially orthopedic care, as the number of children without coverage increased due to more frequent Medicaid renewals.²⁶

Problems Managing and Monitoring Care

Health plans and providers report that even short gaps in coverage can affect their ability to manage care effectively.²⁷ Continuity of care may be particularly difficult to achieve for individuals enrolled in managed care plans if churning prompts or forces them to change plans or providers when their coverage is restored.²⁸

Confusion over reassignment to plans and providers. State policies regarding assignment to health plans and providers following a gap in coverage can affect whether families have a medical home or receive seamless care. The Neighborhood Health Plan of Rhode Island reports that, if an individual leaves the plan and then reenrolls after 90 days without identifying a provider upon reenrollment, he or she is randomly assigned to a primary care site. Individuals’ continuity of care may be compromised unless they are aware that they must affirmatively request to return to the same provider.²⁹ The Community Health

Centers of King County in Washington reports that, after a gap in coverage, it takes two months for a family to reenroll in a managed care plan. Some families assume that they have to choose a new provider when they reenroll. If they contact the health center that had been their medical home, staff there often have to help with reassignment in order to ensure continuous care.³⁰

Disease management programs can be compromised. Many health plans develop disease management programs to improve care and contain costs. When participants lose and regain coverage, they cannot consistently participate in such programs and their effectiveness may be compromised.³¹ The director of disease management at Optima Health Plans in Virginia notes:

Member disenrollment is a big problem for us. It causes a break in services that can be critical for our members. . . . We lose critical data during a period of disenrollment. Medication adherence can be critical to the success of our interventions, and when we lose the data, we lose the ability to track medication refills, and therefore adherence. Members come to depend on our coaching and our expectations of their management of their conditions. We work very hard to establish relationships with them of trust and development of personal responsibility and autonomy. When service breaks, they often feel abandoned, and slip back.³²

In addition, insurance instability may affect the type of care health plans choose to provide. Managed care organizations may have less incentive to provide services to new enrollees since they know that there is likely to be turnover.³³ They may choose not to invest in preventive care, for example.³⁴

Measuring quality of care is difficult. Efforts to measure and improve the quality of care are compromised when health plan members do not participate in the plan for a continuous period and therefore cannot be included in measurements of quality of care.³⁵ The Health Plan Employer Data and Information Set (HEDIS) system, which is used to measure quality in health plans, requires that plans report on measures for members who have been enrolled continuously for certain periods of time. Such a system cannot be effective if measures cannot be reported for large portions of plan enrollees. For example, a review of data across 12 states found that, on average, only 39 percent of children with Medicaid coverage who turned two in the study year met the HEDIS continuous enrollment requirements for measuring the appropriate receipt of immunizations.³⁶

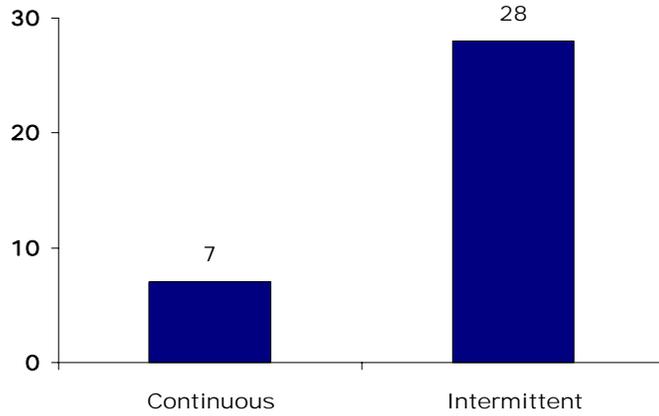
Delayed Care, Inappropriate Care, and Costlier Care

When insurance coverage is unstable, patients and providers have difficulty accessing needed medical care. A recent study that examined health care patterns for children by insurance status shows that, relative to children with full-year coverage, children with gaps in health insurance coverage are more likely to delay care and less likely to seek medical care, including preventive care; have a usual source of care; or have prescriptions filled.³⁷ A survey of low-income families in Oregon shows that 39 percent of children with insurance gaps had to change their regular clinic due to insurance change or loss. The children with gaps in coverage were less likely than those with continuous coverage to receive needed medical care or to fill prescriptions and were more likely to skip medication doses. Children with gaps greater than six months had the highest rates of unmet need.³⁸ Data from a national survey show similar patterns among adults. Those with recent coverage gaps were two to three times as likely as adults with continuous coverage to have postponed care, not to have received care, or not to have filled a prescription because of the cost.³⁹

Compared with those insured for a full year, individuals who have gaps in coverage are less likely to report that they have a usual source of care other than an emergency room and less likely to be confident about access to care. These problems are more commonly reported as the span of time without coverage increases.⁴⁰ A national study of preschool children found that having a gap in health insurance coverage is an important determinant for not having a regular source of care. The study's authors note that the coverage gaps may be particularly harmful for children with emerging disabilities, chronic illnesses, or birth defects.⁴¹ Data from California show that, among the nonelderly population, individuals who are uninsured for part of the year are less likely than those insured all year to have a usual source of care and more likely to have delayed care for cost or insurance-related reasons.⁴² The RIte Care Family Health Survey, which compared groups of children in Rhode Island with intermittent and continuous coverage over a one-year period, showed that families of children with intermittent coverage were four times more likely than those with continuous coverage to report that their children had experienced difficulty accessing medical care (Figure 5).⁴³

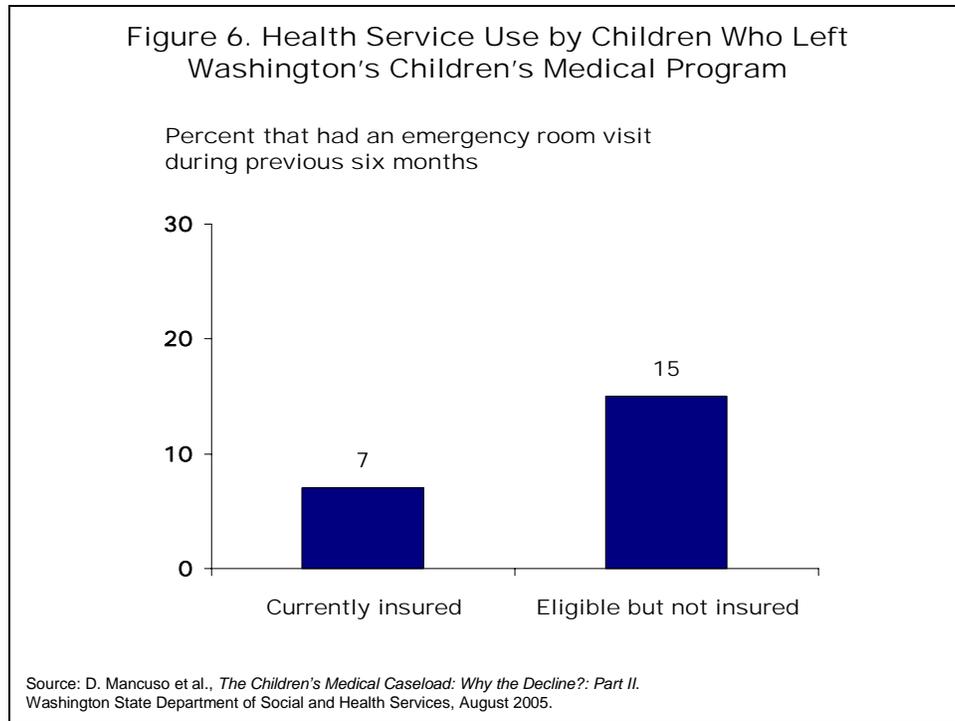
Figure 5. Parent Responses on Children's Ability to Obtain Care, Affected by Continuity of Coverage in Rite Care

Percent reporting difficulty getting medical care



Source: J. Griffin, *Do Gaps in Children's Health Coverage Make a Difference?* Results of Rite Care Family Health Survey, Sept. 2004.

Less appropriate and more costly care. When continuity of care is interrupted, as is likely with intermittent coverage, service use may be less appropriate and may occur in more costly settings. Researchers in Washington State examined health service use for two groups of children after they left the Children's Medical Program. One group had insurance after they left public coverage. The other group was uninsured, although the children appeared to be eligible for public coverage. Families in this second group had a high likelihood of churning, with 88 percent indicating that they would reapply for public coverage. The uninsured children visited an emergency room more than twice as often during a six-month period as those in the group with no coverage gap (Figure 6).⁴⁴



The disruption in patient-provider relationships associated with coverage gaps also appears to be related to higher emergency room use. A review of Medicaid records in Delaware indicates that children and adults with Medicaid coverage who saw a single health care provider in the course of a year were significantly less likely to make an emergency room visit than those with Medicaid coverage who did not have a stable provider relationship.⁴⁵ Similarly, a study of children with Medicaid coverage in Washington showed that greater continuity of primary care was associated with a lower risk of emergency room use and hospitalization.⁴⁶

Coverage gaps and the associated delays in seeking care can result in higher medical costs when people regain coverage and seek care. An analysis from Florida indicates that lapses in Medicaid coverage among beneficiaries with diabetes are associated with higher levels of hospital admissions and emergency room visits in the period immediately following the lapse, relative to the period preceding the lapse. The analysis suggests that lapses may lead to additional Medicaid expenditures.⁴⁷ A study from Utah finds that, among Medicaid beneficiaries with a diagnosis of schizophrenia, those who had interruptions in coverage had, on average, a significantly greater use of Medicaid-financed inpatient psychiatric services than those with continuous Medicaid coverage.⁴⁸ Data from other studies show higher proportions of children visiting physicians in the first six months after enrollment in a health plan than in the second six months after enrollment, and a

decrease in emergency department use as the length of children's enrollment in health plans increased.⁴⁹

Similarly, the literature suggests that more stable coverage may reduce health service costs. According to an analysis of data from the Medical Expenditure Panel Survey, average monthly Medicaid expenditures fall as people remain enrolled for longer periods. Each month of Medicaid enrollment reduced Medicaid expenditures for individuals with incomes below 200 percent of the federal poverty level an additional \$6.49 per month.⁵⁰ An analysis of the potential impact of promoting continuous coverage in Medicaid concludes that continuous coverage could lower monthly payments per enrollee and suggests that, over time, overall health care costs could be reduced as acute episodes are prevented or treated at an earlier stage and management of chronic conditions improves.⁵¹

REASONS AND REMEDIES FOR CHURNING

Over the past several years, state and national studies and reports have examined the causes of coverage instability and churning and offered valuable recommendations for steps that can be taken to improve stability. This section reviews that literature and presents new evidence from the four study states showing that instability and churning are not intractable problems. Policies and procedures can make a tangible difference—in some cases a substantial difference—in promoting retention among eligible children and families and reducing the negative consequences of churning, including higher administrative and treatment costs. While a range of practices can contribute to coverage stability, a few key measures appear to be particularly effective in achieving more stable and cost-effective coverage for children and families.

Reason: Low Renewal Rates

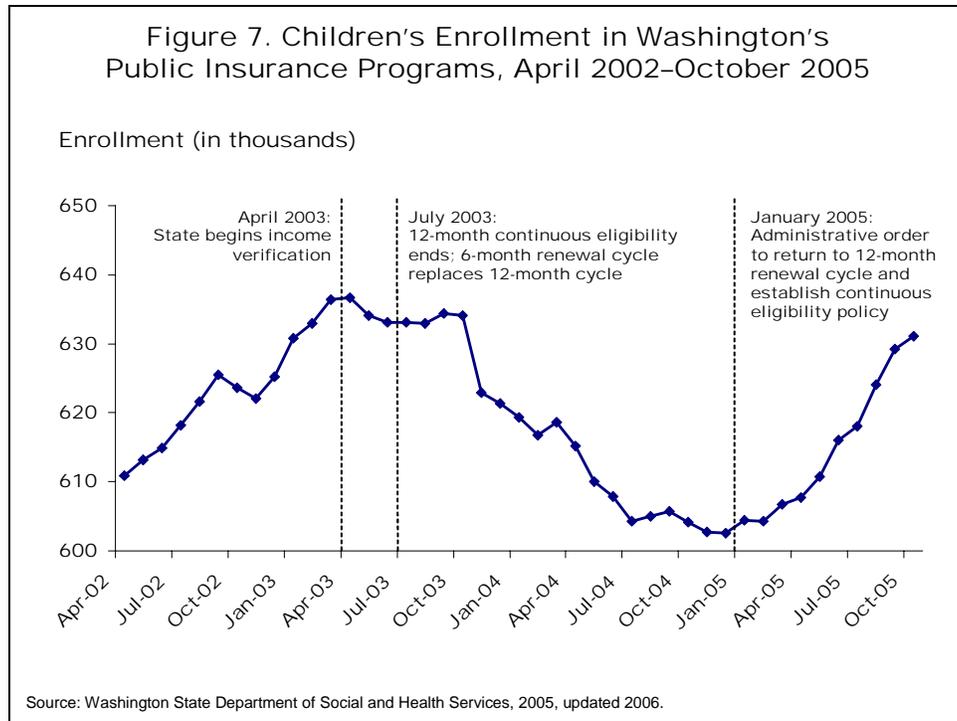
Several studies have found that instability and churning are driven to a significant degree by low public coverage renewal rates. These studies, along with the experiences of the four study states, identify many factors affecting renewal rates, with their relative importance varying by state or locality. Families' lack of awareness of the need to renew and complicated and time-consuming renewal processes are most often cited as factors leading to failure to renew coverage. Complex renewals processes can be particularly onerous for parents who cannot take off time from work or lack the transportation or child care needed to attend interviews, collect documents, and satisfy other requirements. Confusing forms, extensive verification requirements, insufficient translated materials, and limited guidance will also affect retention.⁵²

Many states have simplified renewal forms, streamlined verification requirements, and provided renewal assistance—important, necessary steps. However, to the extent that there is broad agreement that instability and churning are largely consequences of low renewal rates, it is not surprising that the solutions that appear to have the most impact are those that go to the heart of the problem: reducing the frequency of renewals and eliminating renewal requests when needed information is already on hand.

Remedy: Reduce Frequency of Renewals

Limiting the occasions when renewal is required is a direct and certain way to limit coverage loss and reduce churning.⁵³ Under federal rules, states must conduct renewals for Medicaid and SCHIP programs at least once every 12 months. They may, however, require more frequent renewals. States also can opt to provide children with up to 12 months of “continuous” eligibility, meaning that coverage remains uninterrupted between renewals regardless of changes in family circumstances. Although this option is only available for children, states can accomplish a similar result for parents through income and asset disregards.⁵⁴ As of July 2005, nine states require renewals more frequently than every 12 months for children and 14 states require more frequent renewals for parents. Seventeen states opt to provide 12-month continuous eligibility for children in Medicaid.⁵⁵

In terms of the effects of renewal requirements, Washington’s experience is particularly instructive. The state changed its renewal policies twice during a relatively short time period and analyzed the impacts on enrollment and churning. In April 2003, the state adopted new income verification requirements (moving away from its previous policy of accepting a family’s statements and verifying the information provided through available databases). It also began to require a signature on renewal forms, thus eliminating the use of telephone renewals. Three months later, in July 2003, the state dropped 12-month continuous eligibility for children and mandated six-month renewals. Following an executive order issued by the new governor in January 2005, the state reversed course. A 12-month review cycle was restored in May 2005 and a 12-month continuous eligibility policy for children was restored in July 2005. The state’s enrollment data show a steep caseload decline for the Children’s Medical Program following the 2003 changes. This decline began to reverse in August 2005, following the governor’s directive (Figure 7).



Looking beyond the drop in enrollment, Washington researchers examined the extent to which more churning occurred after six-month renewals and other policy changes were implemented. They found that churning rose by 12 percent and that the proportion of children reenrolling in the Children's Medicaid program after having lost coverage because of a failure to complete the eligibility review increased substantially after the April 2003 changes.⁵⁶

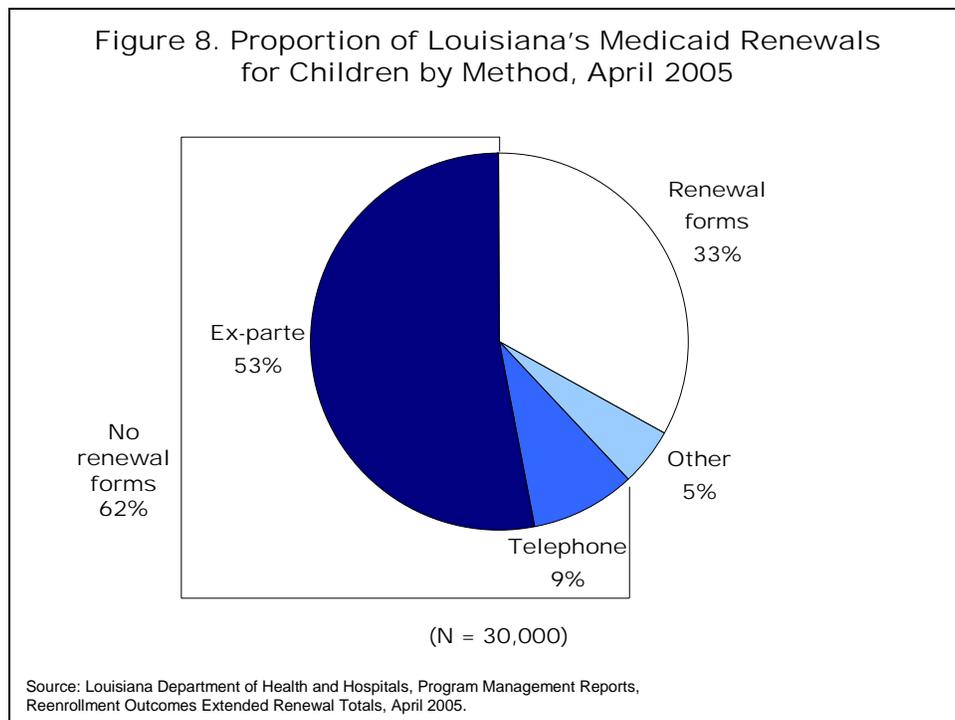
Remedy: Reduce Redundancy at Renewal

Redundancy occurs when families are asked to submit information that is already known or available to the state agency. There are many ways that states can and have reduced redundancy at renewal. Some have streamlined or eliminated requests for documentation, relying primarily on technology to verify eligibility (e.g., wage reporting databases, Social Security Administration data).⁵⁷ A few states use pre-filled renewal forms so that families only need to provide information that has changed since the last application or renewal.⁵⁸ However, the evidence of the impact of pre-filled forms on enrollment patterns is mixed, suggesting that this approach alone is not likely to dramatically reduce churning.⁵⁹

Many states have focused on reducing coverage losses by streamlining renewals, but Louisiana has been particularly aggressive in eliminating unnecessary and redundant requests for information. Its most successful strategy, in terms of impact on renewals, has been to check information otherwise available to the Medicaid agency before sending

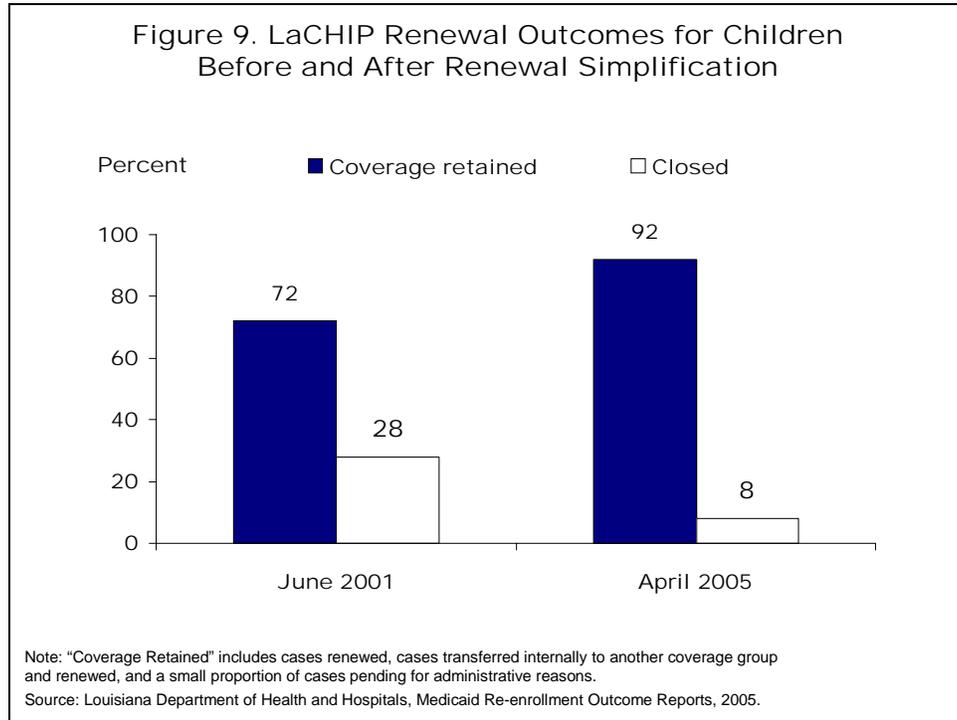
families a renewal form. Known as an “ex parte” renewal, this process eliminates unnecessary paperwork for the agency and families by relying on information that is already on hand, for example from Food Stamp Program records. The process is permitted, and in some situations even required, by federal Medicaid rules.⁶⁰ According to Louisiana officials, ex parte reviews, which were introduced in July 2001, consume less time for agency workers than an application-based renewal. They are far less time-consuming than a case closing and subsequent case opening. State data show that this procedure has helped to reduce dramatically the number of children losing coverage at renewal.⁶¹

According to program management data, as a result of these reforms, only one-third of Medicaid enrollees are required to submit renewal forms during April 2005. More than half of the enrollees had ex parte renewals, for which no direct contact with the family is necessary. Another 9 percent renewed by telephone; these families are contacted by the agency, but no renewal form is required (Figure 8).



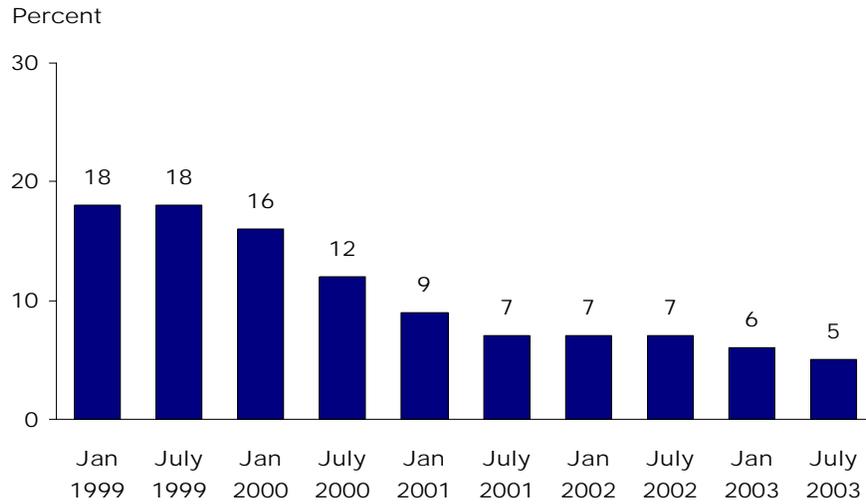
The reduction in the number of families having to complete and return renewal forms has had a significant impact on renewal rates. Between June 2001, when the state first collected data on renewal outcomes, and April 2005, the proportion of children who retained eligibility at renewal jumped from 72 percent to 92 percent (Figure 9). The

proportion of enrollees losing coverage because of failure to return forms has dropped from 17 percent to just 2 percent.



These renewal policies have also contributed to a decrease in churning. Researchers in Louisiana's Division of Health Economics examined enrollment patterns over a two-year period for cohorts of children enrolled in the program. The cohorts were identified beginning in January 1999 and at six-month intervals until July 2003; each cohort was followed for a two-year-period. Over time, as the policy changes were implemented, the proportion of children with gaps in coverage decreased steadily (Figure 10).

Figure 10. Proportion of Coverage Gaps for Cohorts of Children in Louisiana's Medicaid Program, January 1999–July 2003



Note: Each cohort was followed for a two-year period. Cohorts include all children eligible in the beginning month who will not "age out" over the subsequent two years.
 Source: Louisiana Department of Health and Hospitals, Division of Health Economics, 2005.

Remedy: Improve the Renewal Process

Lack of awareness about the need to renew coverage and confusion about the process are frequently cited as reasons that renewal does not occur. Such problems are particularly likely to occur among families who speak a first language other than English.⁶²

Data from Virginia suggest that state policies and procedures affect how well people understand their renewal responsibilities. In Virginia, researchers found marked differences among families that participate in the FAMIS and FAMIS Plus programs, with FAMIS families indicating more familiarity with the renewal process. These differences track the significantly different procedures used in the two programs to notify families and follow up with them about the need for renewal (Table 2).

Table 2. Procedures Used by Virginia Public Health Programs to Notify Families About Renewal

	FAMIS (SCHIP)	FAMIS Plus (Medicaid)
What type of renewal forms are sent to families?	Renewal packet with a letter, renewal form with some individual information pre-printed, and an instruction sheet	Standard one-page renewal form implemented December 2005
Is an envelope with return postage included?	Yes	Not usually
How far in advance of the end of the eligibility this renewal notice sent?	Renewal packet is sent at 10 weeks	Renewal form is sent at four weeks
Do families receive information that renewal is coming up before the renewal forms are sent?	Postcard to announce that renewal is approaching is sent at 12 weeks	No
Do enrollees receive reminders (other than the required advance notice of termination) if they have not responded?	Up to two reminder calls are made, to work and home numbers	No
Are the forms and notices available in languages other than English?	Yes, in Spanish, including pre-filled renewal applications	Renewal forms in other languages may be available in some localities
Are address changes tracked systematically?	Both the renewal postcard and the renewal packet are marked "Return Service Requested" so that eligibility workers can follow up on address changes before the end of the eligibility period	No

Source: Virginia Department of Medical Assistance Services.

Reason: Transitions Among Public Programs

Relying on information from other public programs, such as the Food Stamp Program, can reduce churning within public health coverage programs. However, experience also shows that transitions in other public programs can have a negative impact on churning. In particular, when families who have been receiving cash assistance (Temporary Assistance to Needy Families or, TANF) or food stamps as well as Medicaid coverage stop receiving TANF or food stamps, they may be at risk of losing their Medicaid coverage as well.⁶³ This is largely due to procedural problems, rather than eligibility. Families that become ineligible for TANF or the Food Stamps Program (or voluntarily decide to drop

these benefits) are not necessarily ineligible for Medicaid; since 1997, eligibility for Medicaid is no longer tied to eligibility for welfare. When the loss of TANF is due to a rise in family income (for example, as a result of a new job) or a family's decision to discontinue receipt of cash assistance, the children are almost certain to remain eligible for Medicaid and often the parents will continue to qualify for Medicaid as well.⁶⁴ Despite parents' ongoing Medicaid eligibility, systems that have historically linked administration of public programs, including renewals, may inadvertently cause coverage gaps.

In states that cover children in two different health programs, shifts in eligibility between SCHIP and Medicaid present risks for coverage gaps. As family income rises and falls, and sometimes even as a child ages, a child's eligibility may change from Medicaid to SCHIP or from SCHIP to Medicaid. A recent study analyzing Census Bureau data from the Current Population Survey estimates that children in states with separate SCHIP and Medicaid programs are 45 percent more likely to lose coverage than children from states with just one child health program.⁶⁵ Federal rules require coordination, but effective systems are needed to ensure that children do not fall between the cracks.⁶⁶ States with separate SCHIP and Medicaid programs are more likely than states that exclusively rely on Medicaid to report that children leaving public coverage were uninsured and likely still eligible for coverage.⁶⁷

Remedy: Ensure Stable Medicaid Coverage Despite Changes in Other Public Programs

Following states' implementation of TANF (beginning in 1997), considerable evidence shows that families were inappropriately losing Medicaid coverage when their TANF cases were closed. Many states took remedial action to address this. Washington State took a number of steps to correct system-based problems that led to the loss of health coverage among children and families. In particular, providing children with 12-month continuous eligibility and making computer system upgrades have promoted coverage stability among eligible children. Now, when non-health benefits for children in Washington end for any reason, their eligibility status is changed electronically and medical benefits automatically continue.

Compared with Washington, Rhode Island's policies and procedures are not as geared toward preventing gaps when families transition off of cash assistance. The state is making some changes in this area to improve continuity of coverage. Currently, RI's Care renewals for children and families who are not receiving cash assistance occur every 12 months and are done by mail. Those receiving cash assistance from the state's Family Independence Program (FIP), however, must renew their Medicaid coverage every six

months and an in-person interview is required. If the family does not renew FIP, both the FIP and RItE Care cases are closed. Families receive a letter advising them that their benefits will end and that they may apply separately for RItE Care. The state is currently developing a more consumer-friendly notice advising families that their six-month renewal will affect their health coverage as well as their FIP benefits, and that they may renew RItE Care even if they do not choose to renew FIP. Further changes might also be considered. With better data exchange between the FIP and RItE Care programs, cases about to close could be reviewed internally (i.e., on an ex parte basis) for RItE Care eligibility. Also, the experience of other states that have successfully addressed transition problems suggests that extending the state's current policy of allowing 12-month renewals for most RItE Care beneficiaries to children and families who have been receiving FIP benefits would reduce churning to a considerable degree.

Remedy: Develop Seamless Transitions Between Medicaid and SCHIP

Among the four study states, Washington and Virginia run separate Medicaid and SCHIP coverage programs. Both states have taken steps to facilitate transfers between the two programs, and their experiences are instructive.

Washington's system facilitates simple and relatively seamless transfers. Although different entities handle renewals for Washington's Family Medical Program (the portion of its Medicaid program that covers children and parents), its Children's Medical Program (its Medicaid expansion for children), and its relatively narrow SCHIP program (for children with family incomes above the Medicaid eligibility levels), the renewal forms and procedures, including 12-month continuous eligibility, are the same for all children. This approach, and the fact that the state's data systems are designed to ensure that information can be shared easily, facilitates seamless transitions among the three components of Washington's public coverage programs for children.

Washington expanded coverage for children through Medicaid prior to the creation of SCHIP and therefore now has a small SCHIP program. In comparison, Virginia did not expand coverage for children through Medicaid and now has a relatively broad, separate SCHIP program. When the current FAMIS program replaced the original SCHIP program in Virginia in 2001, the state administered its new SCHIP program without much connection to Medicaid. Enrollment growth in both programs was quite low relative to growth experienced in other states.⁶⁸ Virginia has taken a number of steps to promote children's enrollment in Medicaid and SCHIP, in part by aligning policies for the two programs (FAMIS Plus and FAMIS). In 2002, the state expanded Medicaid modestly to eliminate age-based eligibility rules, developed a single application form for

both programs, and adopted uniform verification requirements. It also adopted a “No Wrong Door” policy, which means that applications can be sent to the FAMIS program’s Central Processing Unit or to local Department of Social Services offices that process FAMIS Plus applications. Applications are processed and enrolled wherever they are received and then forwarded to the other office for case management as needed. However, significant differences between the renewal processes for FAMIS and FAMIS Plus as outlined in Table 2 remain. These differences likely contribute to churning in the state.

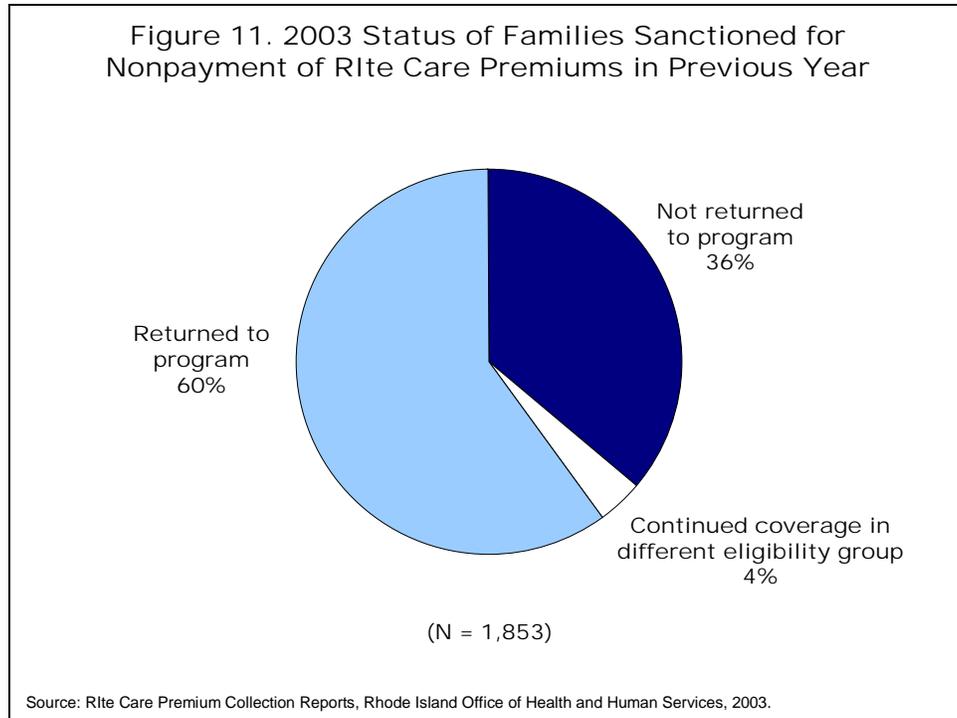
Reason: Premiums Affect Churning

There is considerable evidence that charging insurance premiums in public health programs can have an impact on coverage stability and churning.⁶⁹ The extent of the coverage loss and churning will depend on the amount of the premiums, the income levels of the families required to pay the charges, the number of family members who gain coverage as a result of the premiums, and the procedures in place to facilitate premium collections, among other factors. Two of the study states, Rhode Island and Virginia, have had some experience with premiums in their public health programs.

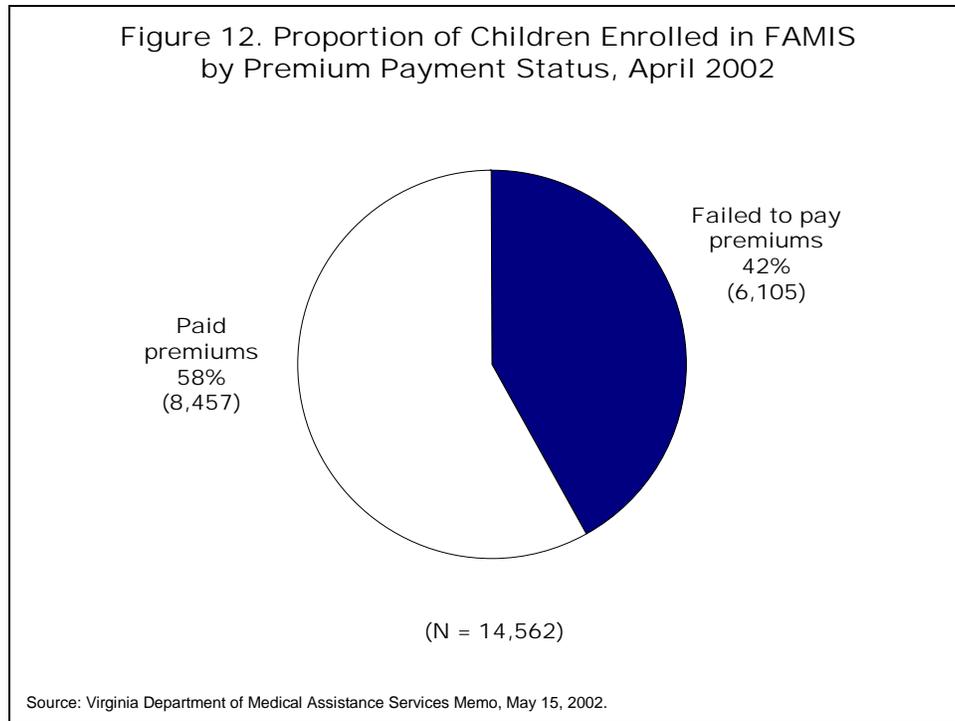
Beginning in January 2002, families in the RItE Care program with incomes above 150 percent of the federal poverty level were charged a monthly premium equal to 3 percent of their income. Sanctions were first imposed in April 2002. With the exception of pregnant women and children under age one, failure to pay the premium for two months results in four months of ineligibility for RItE Care. In August 2002, the monthly premium increased to about 5 percent of income, ranging from \$61 to \$92 per month for a family of three. According to program data, about 10 percent of families participating in the RItE Care program are required to pay premiums. Some participants receive family coverage in exchange for the premiums, while those with incomes above 185 percent of the poverty level receive coverage for their children only.

After steady increases, enrollment flattened somewhat after premiums and sanctions were introduced. Program data show that about 20 percent of those required to pay premiums are dropped from the program for nonpayment each month.⁷⁰ Among those whose premium payments are not directly deducted from their paychecks, the monthly coverage loss doubles, to about 40 percent.⁷¹ The RItE Care Premium Follow-up Survey found that, from July to December 2003, nearly half of enrollees who did not pay their premiums (49%) were uninsured after they left RItE Care and three-quarters of this group of uninsured (75%) said they planned to reapply for RItE Care at the end of the four-month sanction period.⁷²

Consistent with these findings, state program data found that 60 percent of the families sanctioned for nonpayment of premiums at any time during 2002 returned to the program at some point in 2003 (Figure 11). According to state officials, a higher proportion of families with income levels of 150 to 185 percent of the poverty line maintain their coverage as compared to families with higher incomes in which only the children are eligible. This suggests that families may be more willing to pay premiums when their entire family, rather than just some members, gains coverage as a result.⁷³



Virginia charged premiums in its SCHIP program, FAMIS, but never imposed sanctions for nonpayment. Families with incomes between 150 and 200 percent of the federal poverty level were charged \$15 per child per month, up to a maximum of \$45 per family. Premiums were temporarily suspended in December 2001 and permanently suspended in April 2002 out of concern over the number of children who would have lost coverage had the sanctions been imposed. State data show that 42 percent of children enrolled in the FAMIS program from families required to pay premiums did not in fact pay them, and would have lost coverage if sanctions had been imposed (Figure 12). Other states' experiences suggest that this extremely high level of nonpayment might have been reduced somewhat over time as families became more familiar with the premium payment requirements.



States also incur substantial administrative costs associated with premium collections. An analysis of the FAMIS premium payment program conducted in 2002 by the Virginia Department of Medical Assistance Services showed that the administrative costs borne by the state from collecting premiums in SCHIP exceeded the amount of premiums collected. The state general fund paid \$1.39 for every \$1.00 collected. This is because the administrative costs associated with collecting the premiums were high and two-thirds of the amount collected was returned to the federal government.⁷⁴

Remedy: Set Affordable Levels, Switch to Enrollment Fees, or Facilitate Payment

As states consider imposing or increasing premiums in response to cost pressures and new Medicaid program options, premium levels will become an increasingly important consideration for policymakers.⁷⁵ While there is no clear line that establishes definitively what is and is not affordable to a low-income family, the evidence is strong that lower-income people are particularly price-sensitive, given their very limited incomes. It is therefore important for states to monitor the impact of premium payments on program enrollment and adjust policies accordingly.

Some states have switched from monthly premiums to annual enrollment fees. Colorado and North Carolina adopted annual enrollment fees when premium charges were found to cause families to disenroll. Alabama’s SCHIP program also relies on annual

enrollment fees. The change from a monthly to annual system reduces administrative costs associated with premium collections. Of course the amount of the enrollment fee will be an important factor influencing participation rates.

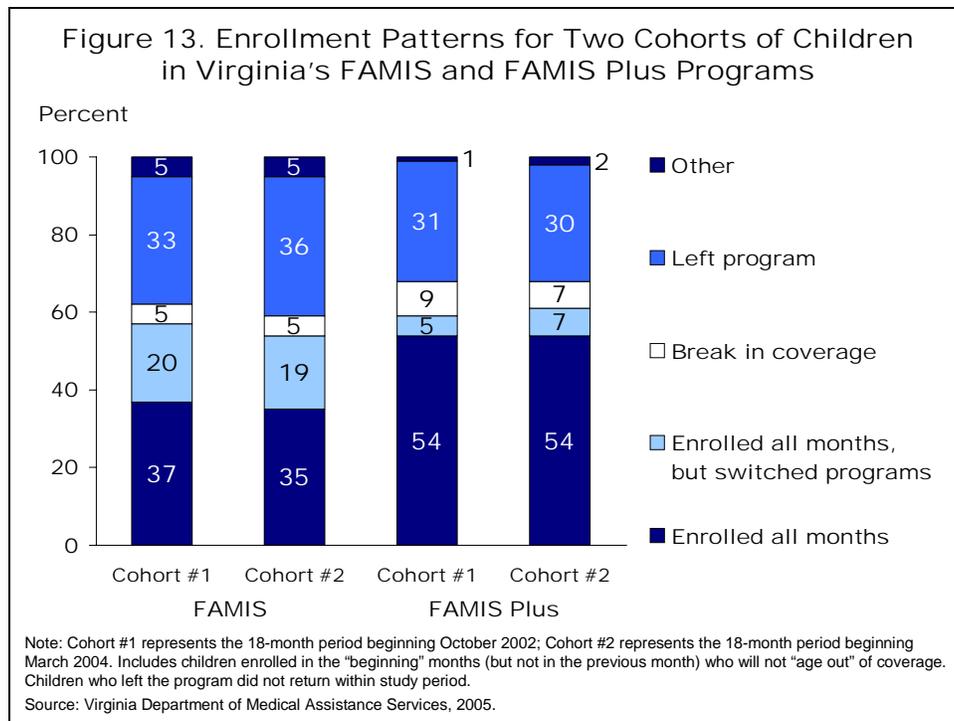
The particular policies governing premium payments and sanctions, as well as the mechanisms available to families to pay premiums, can also affect the stability of coverage. A few states do not impose premium sanctions until renewal, at which time families can catch up with arrears, show that their income has declined, or demonstrate that they have another good cause for nonpayment. Oregon experienced a significant drop in its adult enrollment when it increased premiums somewhat, eliminated the grace period, and discontinued a policy that had allowed premiums to be waived when people were homeless or experiencing other hardships.⁷⁶ Rhode Island is currently setting up systems to permit families to pay premiums in cash at various locations, including convenience stores.

LESSONS LEARNED

A key lesson emerging from the literature, state data, and stakeholder interviews is that policies and procedures matter. Changing family circumstances will inevitably result in some degree of instability in coverage. Yet, certain policies and procedures can reduce instability and churning to a significant degree. In addition, measuring progress (or lack thereof) can make a significant difference, as can leadership in state government, local program offices, and the community.

Routine and Standardized Measurement Is Needed

Consistent, routine measurement of enrollment, disenrollment, and churning rates can show what does and does not work to stabilize coverage and signal when adjustments are needed. Measurement can also establish accountability. Virginia, for example, conducted an analysis for this project which provided new information for administrators to use about the extent to which children left or switched programs. (Figure 13).

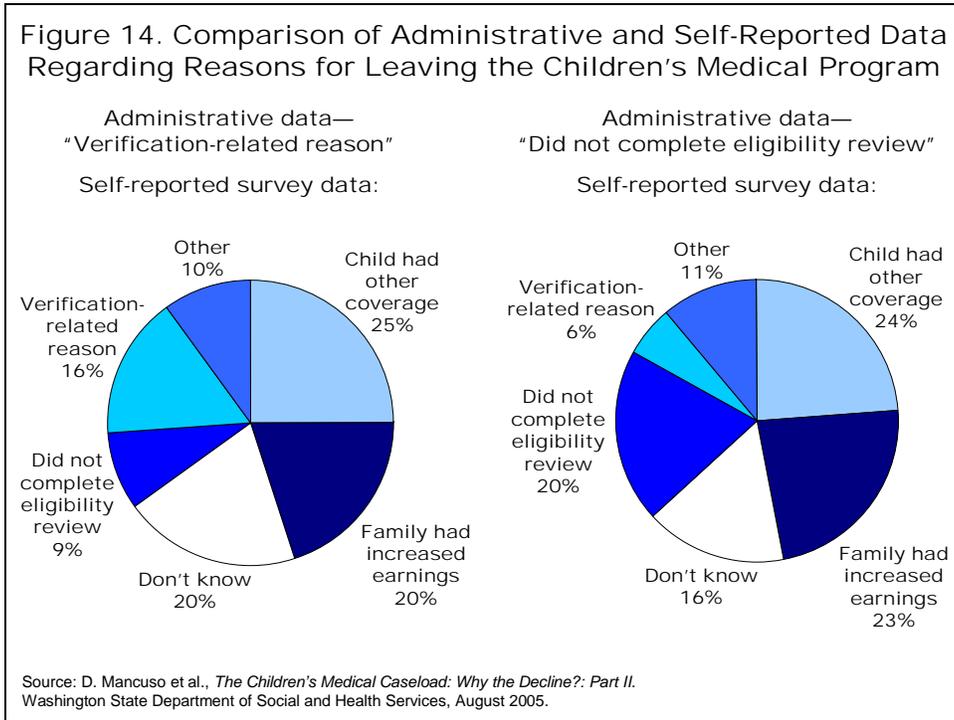


All states collect enrollment data, but not all collect data that provide a clear picture of enrollment dynamics. At a minimum, it is important to know how many people are entering and exiting a program each month. Other vital measures include renewal rates and the reasons for case closings at the point of renewal. The Louisiana Department of Health and Hospital examined statewide renewal rates as well as local rates—enabling comparisons among regional offices. Each region was then asked to develop a plan to improve retention, and the results of their efforts will be tracked over time.

Program and plan administrators frequently cited the need for standards regarding methods to measure insurance instability and churning.⁷⁷ Most states do not keep updated statistics on the proportion of renewals that take place, and so there is little information available on an ongoing basis about how many children lose coverage at renewal.⁷⁸ Also, past efforts to collect data on eligibility renewal outcomes indicate that states vary considerably in their capacity to report on renewal outcomes. Some state databases do not distinguish between cases closed at renewal and other case closures.

In addition, administrative data do not always capture families' perceptions of the reasons for the renewal failure. A survey of parents whose children left Washington's Children's Medical Program compared the reasons for loss of coverage recorded in administrative records with the reasons given by parents who had lost coverage. The

comparison suggests the need for more explicit and consistent coding regarding the reasons for loss of coverage (Figure 14).



Not only are there limited data on churning rates, but the data are not comparable across states because the analyses define and measure churning differently. In states that do track renewal outcomes and report on reasons for closures, data elements and definitions differ considerably.⁷⁹ Researchers and analysts noted that they would prefer not to “reinvent the wheel,” and so would welcome recommendations based on experience in other states. Administrators said that, in setting program goals, it would be helpful to have a definition of a reasonable level of churning and understand how that level should be calculated.

Leadership Is Key

The experiences across states underscore the importance of providing strong leadership at the top and letting people on the ground improvise and adapt. States with explicit goals to increase enrollment and stability of coverage are better positioned to conduct comprehensive reviews of program renewal procedures, make changes, and revisit policies when changes do not produce desired results.

The four study states have demonstrated considerable leadership and commitment to solving instability and churning problems. Rhode Island has a long history of making

coverage improvements, aided by the state Medicaid agency's close collaboration with providers, plans, and advocates.⁸⁰ Virginia and Washington's governors each issued executive directives that spurred efforts to increase enrollment among eligible children. In Virginia, the governor made a campaign promise to enroll all eligible children and then made it a priority of his administration once elected. Observers in Washington note that the governor's leadership in reversing renewal policies by executive order was key.

Louisiana's success in stabilizing coverage for low-income children is due in great part to recognition of the need for system-wide changes, including upgrading computer systems, increasing data collection, developing management reports, and providing ongoing and consistent training regarding policy changes. Comprehensive changes in the renewal process were accompanied by an explicit philosophical shift that made retention among eligible children a priority. The state's deputy director reports, "All Medicaid eligibility management and first line supervisors were trained in the agency's new philosophy. This internal marketing was very important for everything that has followed."⁸¹

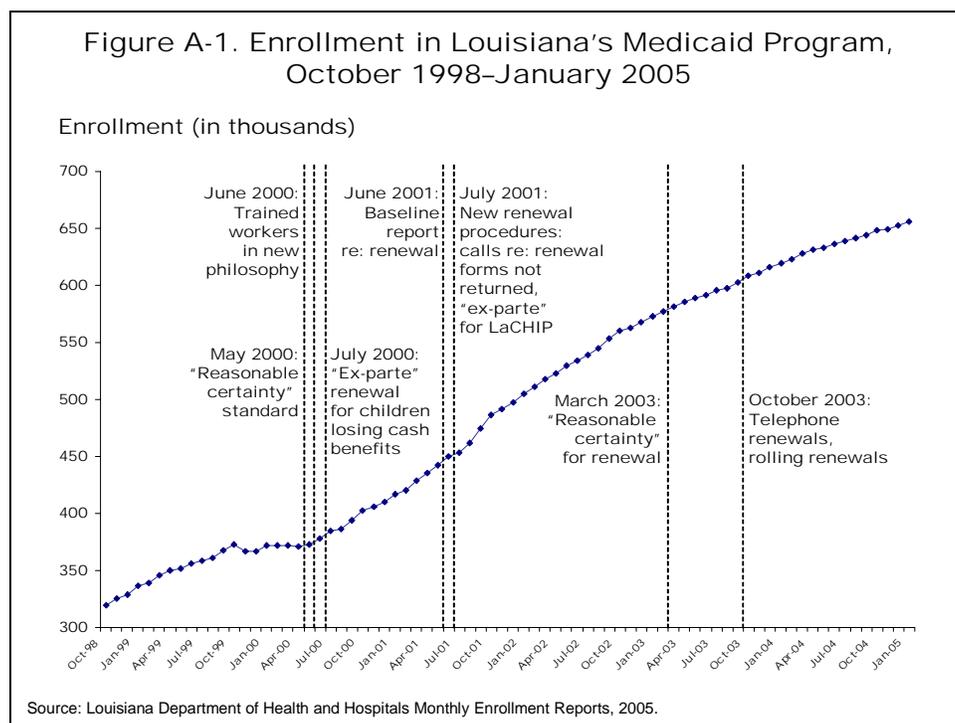
CONCLUSION

There is clear evidence of a considerable degree of coverage instability and churning in the U.S. health care system generally and within public coverage programs. The significant cost and health consequences for children and families, programs, health plans, and providers have been well documented. It is also evident that insurance instability in public programs can be reduced substantially. Proven techniques are available and success is possible when coupled with a commitment to improve and maintain high coverage participation rates among eligible children and families.

APPENDIX. HEALTH PROGRAM ADMINISTRATION IN STUDY STATES

Louisiana

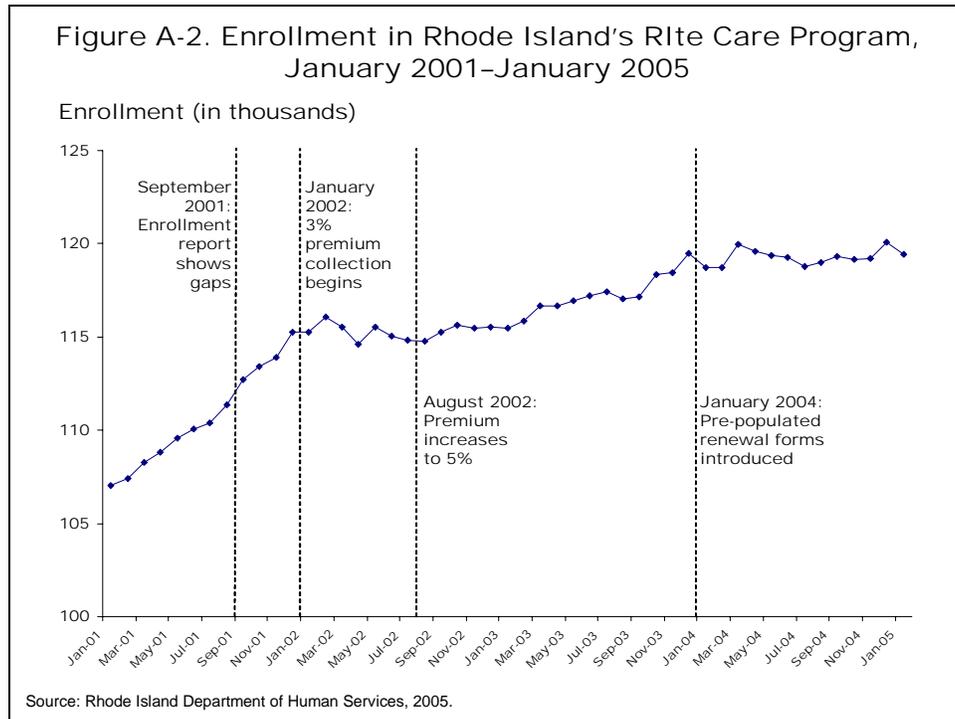
Louisiana provides public insurance coverage through LaCHIP, a Medicaid program. SCHIP funds have been used to expand Medicaid so that benefits are available for children with family incomes below 200 percent of the federal poverty level. Parents are eligible if their income is at or below 13 percent of the federal poverty level. Eligibility for all LaCHIP applicants and benefit renewal for all enrollees are handled by state employees at local offices. The LaCHIP program does not contract with managed care organizations, but uses primary care case managers. Approximately 656,000 children were enrolled in LaCHIP in January 2005. A series of policy changes to simplify the renewal of benefits have been implemented since June 2000 (Figure A-1).



Rhode Island

Rhode Island's RItE Care program is an expanded Medicaid program that uses Medicaid and SCHIP funds to provide coverage for children with family incomes at or below 250 percent of the federal poverty level and parents with family incomes at or below 185 percent of the federal poverty level. State employees working in local district offices make eligibility determinations for RItE Care. Program renewals are handled by a central state office, except for RItE Care enrollees who also receive cash assistance and/or food stamps. Renewals for these enrollees are handled at local district offices. RItE Care contracts with managed care organizations to provide services.

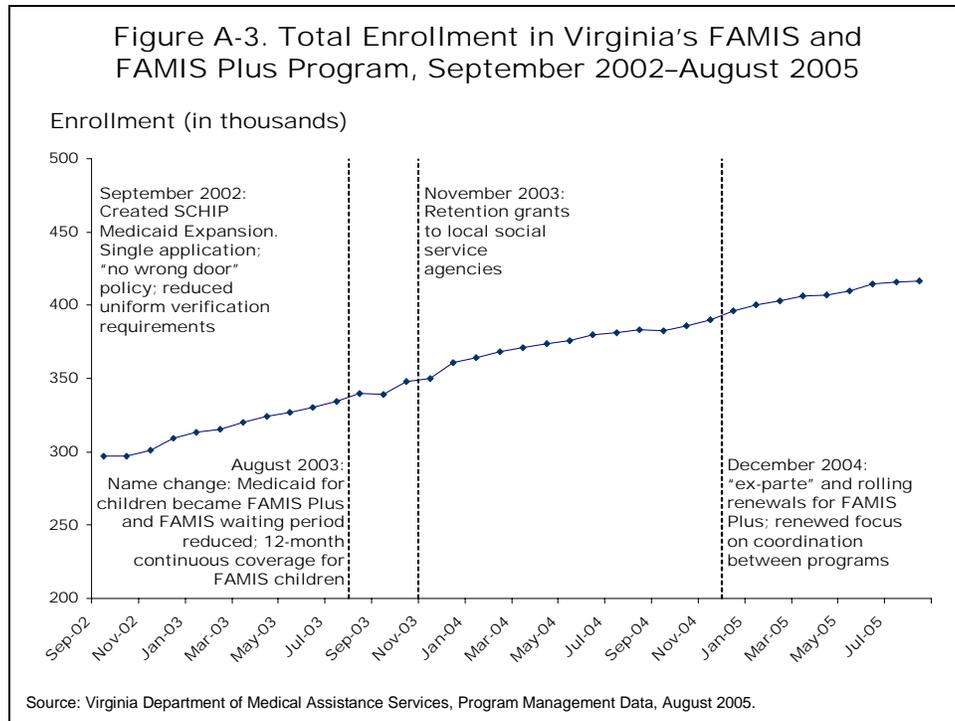
Approximately 74,000 children and 40,000 adults were enrolled in RItE Care in December 2004, and an additional 5,900 children and adults were enrolled in RItE Share, the state's Medicaid-financed premium assistance program.⁸² Some changes to RItE Care policies and practices over the years may have had an impact on enrollment (Figure A-2).



Virginia

Virginia operates two separate public insurance programs for children, FAMIS, a SCHIP program, and FAMIS Plus, a Medicaid program. SCHIP funds finance the FAMIS program and a small Medicaid expansion. Between the programs, coverage is available to children with family incomes at or below 200 percent of the federal poverty level. Parents are covered if their income is below 24 percent of the federal poverty level. Eligibility and renewal determinations for FAMIS are made by a Central Processing Unit. FAMIS Plus eligibility and renewal determinations are conducted locally by Department of Social Services' employees across the state. Managed care organizations provide services for both programs.

In three years, from September 2002 to August 2005, enrollment in the two programs increased from 297,000 to just under 418,000. A number of activities designed to increase enrollment and enrollment stability were implemented over that period of time (Figure A-3).

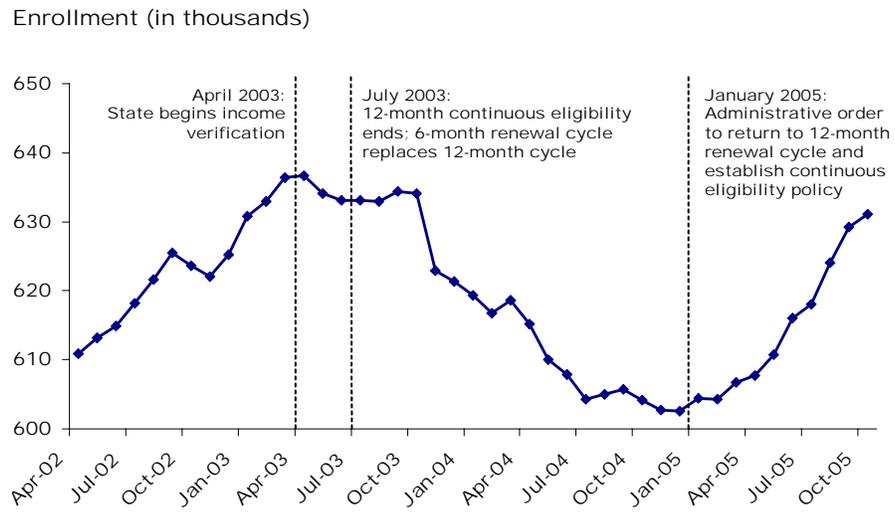


Washington

Public health insurance coverage is available to children in Washington through the Family Medical Program, which provides Medical coverage for children who also receive cash assistance; the Children’s Medical Program, also a Medicaid program; and a relatively small, separate SCHIP program. Among the three programs, children with family incomes at or below 250 percent of the federal poverty level can qualify for benefits. Parents with incomes below 43 percent of the federal poverty level also qualify for Medicaid coverage. In addition, Washington administers the state-funded Basic Health Plan, which covers adults not eligible for Medicaid.

Enrollment and renewal determinations for the Family Medical Program and the Children’s Medical Program are made at local Community Services Organizations, which are staffed by state employees. A centralized Medical Eligibility Determination Unit processes enrollment and renewal applications for SCHIP, though the forms can be sent electronically from Community Services Organizations. Managed care organizations provide services to program enrollees. Significant policy changes associated with the stability of public coverage have occurred in Washington over the past few years (Figure A-4).

Figure A-4. Children's Enrollment in Washington's Public Insurance Programs, April 2002–October 2005



Source: Washington State Department of Social and Health Services, 2005, updated 2006.

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²⁴ Figures are not adjusted for inflation.

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⁷⁰ Rhode Island Medicaid Research and Evaluation Reports, Issue Briefs #4: Results of RItE Care Premium Follow-up Survey, Jan. 2003; #6: Results of RItE Care Premium Follow-up Survey -- #2, July, 2004 (Providence, RI); RItE Care/RItE Share Cost Sharing Reports, FY 2002, 2003, 2004.

⁷¹ Tricia Leddy, state official, Rhode Island Department of Human Services. About half of the people who are subject to premiums are enrolled in Medicaid through the RItE Share program. In RItE Share, eligible families enroll in available employer-sponsored coverage and the Medicaid program picks up the employee's share of the premium for the private health plan and provides wraparound coverage for cost-sharing and benefits. The employee's firm deducts the private plan premiums from the employee's paycheck and the RItE Share program reimburses the employee for that private premium, less the required RItE Share premium. Essentially, therefore, RItE Share enrollees pay their RItE Share premiums through their payroll deductions.

⁷² Rhode Island Medicaid Research and Evaluation Reports, *Results of Rite Care Premium Follow-up Survey—#2*. Issue Brief #6, July 2004.

⁷³ Tricia Leddy, state official, Rhode Island Department of Human Services, Rhode Island. In Rhode Island, premiums are charged all families with incomes above 150 percent of the poverty level, but family coverage extends only up to 185 percent of the FPL. Above that income level, premiums will only cover the children in the family who are enrolled in Rite Care or Rite Share.

⁷⁴ Source: Virginia Department of Medical Assistance Services memo, May 15, 2002.

⁷⁵ Between July 2004 and July 2005, 10 states either increased or adopted measures to increase premiums for children (in Medicaid or in SCHIP) to some degree while one state reduced premiums in its SCHIP program; D. Cohen-Ross and L. Cox, Oct. 2005, Table 15.

⁷⁶ M. J. Carlson and B. Wright, *The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population* (The Office for Oregon Health Policy and Research, Mar. 2, 2005).

⁷⁷ State Medicaid Directors Managed Care Technical Advisory Group, Oct. 6, 2004; Rhode Island Site Visit, Mar. 25, 2005; Virginia Site Visit, Mar. 17, 2005.

⁷⁸ G. Fairbrother, H. L. Park, and A. Haidery, July 2004.

⁷⁹ I. Hill and A. W. Lutzy, June 2003.

⁸⁰ National Health Policy Forum, "Doing It RItE: Exploring a Decade of Health Coverage Innovation," The George Washington University. Rhode Island, May 27–29, 2003; Rhode Island Kids Count, *Health Insurance for Children and Families* (Providence, RI: Mar. 2003).

⁸¹ Ruth Kennedy, state official, Louisiana Department of Health and Hospitals, Louisiana.

⁸² Rhode Island Department of Human Services. *RItE Care/RItE Share Cost Sharing Report: SFY 2006*. Dec. 7, 2005.

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